CHAPTER 800

FEE-FOR-SERVICE QUALITY AND UTILIZATION MANAGEMENT

800 CHAPTER OVERVIEW 800-1

- REFERENCES 800-1

810 UTILIZATION MANAGEMENT OVERVIEW 810-1

- PRIOR AUTHORIZATION 810-1
- CONCURRENT REVIEW FOR HOSPITAL SERVICES 810-4
- MEDICAL CLAIMS REVIEW 810-7

820 PRIOR AUTHORIZATION REQUIREMENTS 820-1

- BEHAVIORAL HEALTH 820-1
- BREAST RECONSTRUCTION AFTER MASTECTOMY 820-1
- COCHLEAR IMPLANTATION 820-2
- DENTAL SERVICES 820-3
- DIALYSIS 820-5
- EPSDT SERVICES 820-5
- EMERGENCY MEDICAL SERVICES 820-6
- EYE CARE/OPTOMETRY SERVICES 820-6
- FAMILY PLANNING SERVICES EXTENSION PROGRAM 820-7
- HOME HEALTH 820-7
- HOSPITAL INPATIENT SERVICE AUTHORIZATION 820-8
- HYSTERECTOMY 820-10
- MATERNAL AND CHILD HEALTH CARE 820-11
- MEDICAL SUPPLIES, DURABLE EQUIPMENT AND ORTHOTIC/PROSTHETIC DEVICES 820-11
- NURSING FACILITY SERVICES 820-14
- OBSERVATION SERVICES THAT EXCEED 24 HOURS 820-15
- PHYSICIANS AND PRIMARY CARE PROVIDERS 820-16

820 PRIOR AUTHORIZATION REQUIREMENTS (CONTINUED) .....

- PODIATRY SERVICES 820-17
- PRESCRIPTION DRUG/PHARMACY SERVICES 820-17
- REHABILITATION THERAPIES (OCCUPATIONAL, PHYSICAL AND SPEECH) 820-18
- TOTAL PARENTERAL NUTRITION 820-19
- TRANSPLANTATION (ORGAN AND TISSUE) 820-22
- TRANSPORTATION 820-24
- TRIAGE/SCREENING AND EVALUATION OF EMERGENCY MEDICAL CONDITIONS 820-26
  - EXHIBIT 820-1 HYSTERECTOMY CONSENT FORM

830 QUALITY AND UTILIZATION MANAGEMENT FOR HOSPITAL SERVICES 830-1

- UTILIZATION REVIEW – RURAL HOSPITALS 830-1

840 INDIAN HEALTH SERVICE REFERRAL POLICY 840-1

800 CHAPTER OVERVIEW

This chapter defines AHCCCS quality management and utilization management (QM/UM) policies for fee-for-service (FFS) providers of AHCCCS covered acute care services. For purposes of this chapter, "member" is limited to FFS members with the exception of Federal Emergency Services Program (FESP) members. For information regarding FESP members, refer to Chapter 1100.

The components of FFS UM discussed in this chapter include:

1. Utilization Management Overview
2. AHCCCS Division of Fee-for-Service Management (DFSM) FFS prior authorization (PA) Requirements and Adverse Decisions notification
3. Concurrent Review for Hospital Services
4. Quality and Utilization Management for Hospital Services, and
5. AHCCCS Indian Health Service Referral Policy.

Refer to Chapters 900 and 1000 for QM/UM requirements for Contractors

- **REFERENCES**

1. Title 42, Code of Federal Regulations (42 CFR), Part 456, Subpart C
2. 42 CFR, Part 441—Services: Requirements and Limits Applicable to Specific Services
3. Arizona Revised Statutes, Title 36, Chapter 29, Articles 1, 2 and 4
4. Arizona Administrative Code, Title 9, Chapter 22, Article 2 (9 A.A.C. 22, Article 2)
5. 9 A.A.C. 28, Article 2
6. 9 A.A.C. 31, Articles 2 and 16

810 UTILIZATION MANAGEMENT OVERVIEW

Utilization management (UM), often referred to as utilization review, is a methodology used by health care professionals for assessing the medical necessity, appropriateness and cost-effectiveness of professional care, services, procedures and facilities.

UM methodologies include, but are not limited to:

1. Prior authorization (does not apply to emergency services)

2. Concurrent review, and/or

3. Medical claims review (retrospective review).

• PRIOR AUTHORIZATION

Description. Prior authorization (PA) is a process by which the AHCCCS Division of Fee for Service Management (DFSM) determines in advance whether a service that requires prior approval will be covered, based on the initial information received. PA may be granted provisionally (as a temporary authorization) pending the receipt of required documentation to substantiate compliance with AHCCCS criteria. PA does not guarantee payment. Reimbursement is based on the accuracy of the information received with the original PA, on whether or not the service is substantiated through concurrent and/or medical review, and on whether the claim meets claims submission requirements.

PA is issued for AHCCCS covered services within certain limitations, based on the following:

1. The member's AHCCCS eligibility at time of PA request, as confirmed through on-line verification

2. Provider status as an AHCCCS-registered FFS provider

3. The service requested is an AHCCCS covered service requiring PA

4. Information received by the AHCCCS/DFSM PA Unit meets the requirements for issuing a PA number, and

5. The service requested is not covered by another payer (e.g., commercial insurance, Medicare, other agency). NOTE: This is determined by asking the provider, and looking into the member's file for other payer information.

Amount, Duration and Scope. PA must be obtained during regular business hours. For services provided on weekends or state holidays, authorization must be obtained on the next business day, but the attending physician should carefully determine the level of service required.

The general procedures for obtaining a PA number prior to providing an AHCCCS covered service are listed below. Providers may call, fax or mail the PA request to the AHCCCS/DFSM/PA Unit as specified below.

1. Providers must:

   a. Call

      1-602-417-4400 (Phoenix area direct line to the PA Unit)

      1-800-433-0425 (In state direct line into the PA Unit)

      1-800-654-8713 (In state line to AHCCCS switchboard; dial extension 74400 or ask for the PA Unit)

      1-800-523-0231 (Out of state line to AHCCCS switchboard; dial extension 74400 or ask for the PA Unit)

      1-602-417-4000 (Phoenix area AHCCCS switchboard and dial extension 74400 or ask for the PA Unit)

   b. Fax Numbers

      PA-(602) 256-6591

      Transportation-(602) 417-4687

c. Mailing Address

AHCCCS-Division of Fee for Service Management
PA Unit, Mail Drop 8900
701 East Jefferson
Phoenix, AZ 85034

2. The following information must be given:

a. Caller name, provider name and provider ID

b. Member/patient name and AHCCCS ID number

c. Type of admission/service

d. Admission/surgery service date

e. ICD-9 diagnosis code(s)

f. CPT procedure code(s) or HCPCS code(s)

g. Anticipated charges (if applicable), and

h. Medical justification.

3. An AHCCCS/DFSM/PA nurse, upon receipt and assessment of information provided, will issue to the calling provider an approval, a provisional PA number or notify them of a denial of coverage.

4. AHCCCS DFSM/PA generates a PA confirmation letter of approval, provisional approval (awaiting additional information), or denial of coverage, which is mailed to the provider the next business day.

For all requirements related to the grievance system, refer to Arizona Administrative Code Title 9, Chapter 34 (9 A.A.C. 34).

5. PA is not required for FFS members receiving services from Indian Health Service (IHS) providers and facilities. Refer to Policy 840 in this chapter for PA requirements for services provided to IHS members.

CONCURRENT REVIEW FOR HOSPITAL SERVICES

Description. Concurrent review may be performed on admission and at frequent intervals during acute inpatient hospital stays. Reviewers assess the appropriate usage of ancillary resources, levels of care (LOC) and service, according to professionally recognized standards of care. Concurrent review validates the medical necessity for continued stay and evaluates quality of care.

- Concurrent review is provided by an AHCCCS contracted review organization that employs licensed health care professionals to perform reviews.

- Concurrent review begins when the AHCCCS/Division of Fee for Service Management/Prior Authorization (AHCCCS/DFSM/PA) Unit notifies the contracted review organization of the admission or need for review.

- Concurrent review is generally initiated by the next business day and continues at intervals appropriate to patient condition, based on the review findings. During review, the following are considered:

    1. Necessity of admission and appropriateness of service setting

    2. Quality of care

    3. Length of stay

    4. Whether services meet the coverage requirements for the eligibility type

    5. Discharge needs, and

    6. Utilization pattern analysis.

Concurrent Review Determinations. The contracted review organization and the AHCCCS/DFSM/PA Unit determine the appropriateness of continued services in consultation with physician advisors, as necessary. If it is determined that service is no longer appropriate, the contracted review agency will initiate a recommendation of denial.

Procedures.

1. Continued hospital services may be denied when:

    a. A member no longer meets intensity and severity criteria, or

    b. A member is not making progress in a rehabilitative program

    c. A member can be transferred safely to a lower LOC, or

    d. Services do not meet the coverage requirements for the eligibility type.

2. The contracted review organization may consult with their physician advisor to review the need for continued stay.

3. The contracted review organization will notify the attending physician and the hospital liaison verbally or in writing regarding a potential denial of coverage and the denial date.

4. The attending physician has one business day to:

    a. Agree: The attending physician agrees that services or stay are no longer appropriate and the denial stands, or

    b. Disagree: The attending physician disagrees and provides information to the contracted review organization justifying medical necessity for continued stay.

5. When the attending physician disagrees, one or more of the following will occur:

Contracted Review Organization Action	Outcome
• Contracted review organization (and their physician advisor, as necessary) agrees with attending -	Stay is extended.
• Contracted review organization physician advisor does not agree on continued stay-	Second contracted physician advisor is consulted.
• If the 2nd contracted physician advisor agrees with the 1st physician advisor to deny continued stay	Stay is denied.
• If 1st and 2nd contracted agency physician advisors disagree	A 3rd contracted physician advisor is consulted and his decision to continue or deny the stay is final.

6. When the final determination is a denial of coverage, denial dates will be effective (as confirmed with the AHCCCS/DFSM/PA Unit) according to a two business day schedule. For example:

   a. The attending physician is notified by the review organization on October 10.

   b. The review organization allows:

      (1) One business day (October 11) for the attending physician's response period and

      (2) One business day (October 12) for verbal notification of the denial to the attending physician and the hospital.

   c. The denial date is effective October 13.

7. The contracted review organization forwards written notification of denial of coverage to all of the following:

   a. The attending physician

b. The hospital, and

c. AHCCCS/DFSM/PA.

8. The contracted review organization:

   a. Immediately notifies the AHCCCS/DFSM/PA Unit verbally, and

   b. Sends a copy of the denial letter to AHCCCS within five business days of initiation of denial.

9. For grievance system requirements, refer to 9 A.A.C. 34.

10. The contracted review organization abstracts are forwarded to AHCCCS with monthly billing, or upon specific case request.

- **MEDICAL CLAIMS REVIEW**

Description. AHCCCS/DFSM/Claims conducts medical reviews of specified claims for each AHCCCS eligibility category to verify appropriateness and effectiveness of service utilization. Criteria for these medical claim reviews focus on factors including, but not limited to: diagnosis, utilization pattern, selected types of surgery and admissions. Focused medical reviews are conducted on a pre-payment basis, and may be applied to a sample of claims or all claims, depending on the reason for conducting the review.

Procedures. AHCCCS/DFSM/Claims Medical Review staff may review claims for physician and professional services rendered, hospital admissions, the level of care provided, and the length-of-stay in conjunction with the admission criteria. All transplant services are reviewed by the AHCCCS Transplant Coordinator.

820 PRIOR AUTHORIZATION REQUIREMENTS

This section identifies AHCCCS Administration FFS PA requirements for covered services for the general FFS population not in FESP. (Refer to Chapter 1100 for all requirements regarding services provided to FESP members.)

The AHCCCS/DFSM procedural requirements for submitting PA requests via mail, fax or over the telephone, as defined in Policy 810, apply to all services identified in this section, unless specified otherwise. For purposes of this chapter, all PA requests are submitted to the AHCCCS/DFSM/PA Unit for approval or denial.

• BEHAVIORAL HEALTH

Description. AHCCCS covers behavioral health services (mental health and/or substance abuse services) within limitations depending upon the member's age and eligibility.

Refer to Chapter 300, Policy 310 and Appendix G of this manual for further information regarding AHCCCS covered behavioral health services and settings.

• BREAST RECONSTRUCTION AFTER MASTECTOMY

Description. AHCCCS covers breast reconstruction for eligible fee-for-service (FFS) members following a medically necessary mastectomy.

Refer to Chapter 300, Policy 310.

The physician performing the procedure and the facility in which the services are provided must obtain (PA) from the AHCCCS Chief Medical Officer, or designee, for breast reconstruction surgery provided to FFS members.

Refer to the sections of this policy addressing Hospital Inpatient Stays and Physician Services for required documentation to receive PA.

- **COCHLEAR IMPLANTATION**

Description. AHCCCS covers medically necessary cochlear implantation for FFS members within certain limits. Providers must obtain approval from the AHCCCS Chief Medical Officer, or designee, for all cochlear implants and related services for FFS members. Requests for PA must include documentation of the appropriate assessments and evaluations for determining suitability for a cochlear implant.

Refer to Chapter 300, Policy 320, and Chapter 400, Policy 430, in this manual for complete information regarding covered cochlear implantation services.

Procedures. FFS provider responsibilities regarding cochlear implantation services include, but are not limited to:

1. The member's implantation specialist (otolaryngologist or otologist) must submit a written request to the AHCCCS Chief Medical Officer, or designee, for approval of the implant.

2. The following documentation must accompany the written request:

    a. The member's current history and physical examination, including information regarding previous therapy for the hearing impairment

    b. Records documenting the member's diagnosis, current medical status and plan of treatment leading to the recommendation of implantation, and

    c. Current psychosocial evaluation and assessment for determining the member's suitability for implant.

3. The AHCCCS Chief Medical Officer, or designee, will review the submitted documentation and provide a written response for approval or denial to the member's implant specialist. If approved, the written response will include the following information:

    a. Designation of the appropriate implantation center with which AHCCCS maintains a contract

b. Instructions for obtaining PA for each implant service component, and

c. Coverage limitations.

4. If a cochlear implant is denied, notice will be provided in accordance with 9 A.A.C. 34.

Refer to the AHCCCS Fee-for-Service Provider Manual for information regarding submission of claims and billing procedures. This manual is available online at the AHCCCS Web site.

- **DENTAL SERVICES**

Description. AHCCCS covers the following dental services for members:

- Emergency dental services
- Medically necessary dentures
- Pre-transplant dental services, and
- Preventive and therapeutic dental services (these services are limited to members who are under the age of 21 in both the Medicaid (EPSDT program) and KidsCare programs).

1. Emergency dental services – Emergency dental services provided to members, as defined in 9 A.A.C. 22, Article 22, do not require PA.

   Limitations for emergency dental services provided to members not enrolled with Contractors include, but are not limited to, the following:

   a. Extractions are limited to emergency care.

b. The treatment for the prevention of pulpal death and imminent tooth loss is limited to non-cast fillings, pre-formed stainless steel crowns, pulp caps and pulpotomies only for the tooth causing pain, or in the presence of active infection. Root canals are limited to six anterior teeth (uppers and lowers) only, and only when indicated as treatment for acute infection or to eliminate pain.

c. Routine restorative procedures and routine root canal therapy are not considered emergency services.

d. Radiographs are limited to use as a diagnostic tool preceding treatment of symptomatic teeth and to support the need and provision of dentures.

e. Maxillofacial dental services provided by a dentist are not covered except to the extent prescribed for the reduction of trauma, including reconstruction of regions of the maxillae and mandible.

f. Diagnosis and treatment of temporomandibular joint dysfunction are not covered except for the reduction of trauma.

2. Medically necessary dentures – For members 21 years of age and older, the provision or replacement, repairs or adjustment of dentures, and provision of obturators and other prosthetic appliances for restoration or rehabilitation requires PA.

3. Pre-transplant dental services - Pre-transplant dental services that are medically necessary in order for the member to receive the major organ or tissue transplant require PA by the AHCCCS Transplant Coordinator.

4. Preventive and therapeutic dental services – Preventive and therapeutic dental services are limited to members who are under the age of 21 in both the Medicaid (EPSDT program) and KidsCare programs. These services do not require PA. Medically necessary orthodontia services that are provided to Medicaid members and KidsCare members under the age of 21 do require PA.

Refer to Chapter 300, Policy 310 and Policy 320 (Affiliated Practice Dental Hygienist Policy), and Chapter 400, Policy 430, for complete information regarding covered dental services.

Procedures. PA requests for medically necessary dentures, pre-transplant dental services and orthodontia services may be submitted via mail, fax or telephone. PA is not necessary in emergency circumstances.

Written dental PA requests must be accompanied by:

1. Referral from member's physician/dentist substantiating medical necessity of services through description of medical condition

2. Dentist's treatment plan and schedule, and

3. Radiographs fully depicting existing teeth and associated structures by standard illumination when appropriate.

- **DIALYSIS**

Description. AHCCCS covers dialysis and related services furnished to AHCCCS FFS members by qualified providers without PA.

Refer to Chapter 300, Policy 310, for covered dialysis services for members not in FESP.

Refer to Chapter 1100 for information regarding FESP dialysis services.

- **EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT (EPSDT) SERVICES**

Description. EPSDT services provide comprehensive health care, as defined in 9 A.A.C. 22, Article 2, through primary prevention, early intervention, diagnosis and medically necessary treatment of physical and behavioral health problems for enrolled AHCCCS members under 21 years of age. EPSDT also provides for all medically necessary services to treat or ameliorate physical and behavioral health disorders, a defect, or a condition identified in an EPSDT screening. Limitations and exclusion, other than the requirement for medical necessity, do no apply to EPSDT services.

PA for these services is only required as is designated in this policy and in Chapter 400, Policy 430.

Refer to Chapter 400, Policy 430, for complete information regarding EPDST services (overview, definitions, screening requirements, service standards, provider requirements and exhibits).

- **EMERGENCY MEDICAL SERVICES**

Description. A provider is not required to obtain PA for emergency medical services; however, a provider must comply with the notification requirements in 9 A.A.C., Article 2.

Notification of emergency admissions may be submitted via fax or telephone. A provider must notify the Administration no later than 72 hours after a FFS member receiving emergency medical services presents to a hospital for inpatient services. The Administration may deny payment for failure to provide timely notice.

Refer to Chapter 300, Policy 310 and Exhibit 310-1, for review of the Rule sections regarding FFS emergency services.

Refer to Chapter 1100 for information regarding the Federal Emergency Services Program.

- **EYE CARE/OPTOMETRY SERVICES**

Description. AHCCCS covers eye care/optometric services for members, within limitations. Coverage is provided as described in Chapter 300, Policy 310.

1. Emergency eye care services do not require AHCCCS authorization.

2. Eye examinations and prescriptive lenses are covered only for EPSDT and KidsCare members. PA is not required. Prescriptive lenses for members age 21 and older are not covered unless they are the sole visual prosthetic device used by the member after cataract removal surgery.

3. Cataract removal requires PA from the AHCCCS/DFSM/PA Unit. Children needing cataract removal should be referred to Children's Rehabilitative Services. Other prior authorization requests for cataract removal services may be submitted via mail, fax or telephone.

- **FAMILY PLANNING SERVICES EXTENSION PROGRAM**

  Description. AHCCCS covers comprehensive family planning services through the Family Planning Services Extension Program for SOBRA women whose eligibility has terminated, who are not eligible for any other AHCCCS services, and who voluntarily choose to delay or prevent pregnancy. These services may be provided for up to 24 months following date of delivery. Any medical service not included in the Family Planning Services Extension Program is not covered.

  Refer to Chapter 400, Policy 420 for a complete discussion of the Family Planning Services Extension Program.

- **HOME HEALTH**

  Description. All home health services require PA from the AHCCCS/DFSM/PA Unit.

  Refer to Chapter 300, Policy 310, for complete information regarding covered home health services.

  Procedures. PA requests for home health services should be submitted by mail, fax, or telephone prior to providing services.

- **HOSPITAL INPATIENT SERVICE AUTHORIZATION**

Description.

Hospital inpatient service authorization is a part of the utilization management process that may consist of both PA and continued authorization, contingent upon concurrent review findings (refer to Policy 810).

Procedures.

Initial Service Authorization:

Under 9 A.A.C. 22, Article 2, the provider must notify the Administration no later than 72 hours after a FFS member receiving emergency medical services presents to a hospital for inpatient services. The Administration may deny payment for failure to provide timely notice.

1. Providers must obtain PA from the AHCCCS Administration for the following inpatient hospital services:

    a. Organ and tissue transplantations (this authorization review is performed by the AHCCCS Transplant Coordinator with the exception of corneal transplants that are submitted to the AHCCCS/DFSM.PA Unit.)

    b. Non-emergency admissions, including psychiatric hospitalizations

    c. Elective surgery, excluding a voluntary sterilization procedure, and

    d. Services or items furnished to cosmetically reconstruct appearance after the onset of trauma or serious injury.

2. Women and their newborns may receive up to 48 hours of inpatient hospital care after a normal vaginal delivery and up to 96 hours of inpatient care after a cesarean delivery. The attending health care provider, in consultation with the mother, may discharge the mother or newborn prior to the minimum length of stay.

3. For retrospectively eligible members, notification requirements are as follows:

   a. When the member is made eligible while still in the hospital, providers must notify the Administration no later than 72 hours after the eligibility posting date for emergency hospitalizations.

   b. When eligibility is posted after the member is discharged from the hospital, the notification requirement in 3(a) will be waived.

4. Payment for services may be denied if the hospital fails to provide timely notification or obtain the required authorization number(s) within the parameters specified in this policy. However, the issuance of an authorization number does not guarantee payment; documentation provided from the member's medical record must support the diagnosis for which the authorization was issued, and the claim must meet clean claims submission requirements.

   Refer to the AHCCCS Fee-for-Service Provider Manual for information regarding pre-payment review criteria and submission requirements. This manual is available online at the AHCCCS Web site.

5. Authorization may be provisional if further review of information or documentation is needed to make a full assessment of the medical necessity for the admission, the service(s), and/or to determine the appropriate length of stay. This information may be obtained through on-site or telephonic concurrent review. Upon approval or denial, the provisional status is removed from the authorization and the provider is notified by letter of the decision.

- **HYSTERECTOMY**

Description. Hysterectomy services require prior authorization (PA) from the AHCCCS./DFSM/PA Unit.

Refer to Chapter 300, Policy 310, for complete information regarding covered hysterectomy services.

Procedures. PA requests for hysterectomy services may be submitted via mail, fax or telephone.

The medical record must document the medical necessity of the hysterectomy, including prior medical and surgical therapy and results. Also, the member must sign a consent form, which includes information that the hysterectomy will render her incapable of bearing children. PA may be granted based on these documents. Providers may use the sample AHCCCS hysterectomy consent form contained in this Chapter, Exhibit 820-1, or they may use other formats as long as the forms include the same information and signatures as the AHCCCS hysterectomy consent form.

The provider is not required to complete a consent to sterilization form prior to performing hysterectomy procedures and the 30-day waiting period required for sterilization does not apply to hysterectomy procedures.

In a life-threatening emergency, authorization is not required, but the physician must certify in writing that an emergency existed.

- **MATERNAL AND CHILD HEALTH CARE**

  AHCCCS covers a comprehensive set of services for pregnant women, newborns and children, including maternity care, family planning services, EPSDT services and KidsCare services.

  AHCCCS requires FFS providers to request PA for pregnancy terminations.

  Refer to Chapter 400 for information on maternal and child health care services.

- **MEDICAL SUPPLIES, DURABLE EQUIPMENT AND ORTHOTIC/PROSTHETIC DEVICES**

  Description. Medical supplies, durable equipment and orthotic/prosthetic devices must be prescribed by a fee-for-service physician or other appropriate practitioner.

  Refer to Chapter 300, Policy 310, for complete information regarding covered medical supplies, equipment and prosthetic devices.

  The following requirements apply to these services:

  1. Prior authorization (PA) is required for medical equipment and orthotic/prosthetic devices exceeding $300.00.

  2. PA is required for consumable medical supplies exceeding $100.00 per month. (Consumable means the supplies have limited or no potential for reuse.)

  3. PA is required for medically necessary incontinent supplies. Refer to Chapter 400, Policy 430, for criteria related to coverage of incontinence briefs for members under the age of 21.

  4. Durable medical equipment may be purchased or rented only when there are no reasonable alternative resources from which the medically necessary equipment can be obtained at no cost. The total expense of renting the equipment must not exceed the purchase price (i.e., if AHCCCS can purchase the equipment for less than the rental fee, AHCCCS will purchase the item.) All rental equipment requires PA.

The following medical supplies, durable medical equipment and orthotic/prosthetic devices are **not** covered by AHCCCS:

1. Personal incidentals including items for personal cleanliness, body hygiene and grooming (except upon prescription by an authorized provider)

2. First aid supplies (except upon prescription by an authorized provider)

3. Hearing aids for members 21 years of age or older

4. Prescriptive lenses for members 21 years of age or older (except when medically necessary following cataract removal without an implanted lens)

5. Incontinence supplies, unless determined medically necessary, or

6. Penile implants or vacuum devices for members 21 years or older.

Procedures. PA for supplies/equipment may be submitted via fax, mail or telephone. (See Policy 810 for addresses.)

In addition to information required for all PAs, specified in Policy 810 of this chapter, the following information must be supplied at the time of the PA request:

1. Name of ordering physician and description of medical condition necessitating the supplies/equipment

2. Medical justification for supplies/equipment and anticipated outcome (medical/functional)

3. Description of supplies/equipment requested, including manufacturer brand name, and product code

4. Duration for use of equipment and full purchase price plus any additional costs and expected cost if rented

5. Provider identification number and diagnosis code, and

6. Home evaluation, when requested by the AHCCCS/DFSM/PA Unit.

The procedure for a telephone request is:

1. After receiving the information outlined above, the AHCCCS/DFSM/PA Unit issues a provisional number to the provider

2. The provider must then submit the information in writing via mail or fax, and

3. Upon receipt of the PA request form with all required documentation, the PA number will be validated and a PA confirmation letter will be mailed to the provider.

The procedure for written (mail or fax) request is:

1. The provider must submit the information outlined above, and

2. Once received, information is assessed and PA confirmation letter is mailed to the provider, denying or approving services.

Requests for authorization of incontinence supplies must include the following information:

1. Diagnosis of a dermatologic condition or other medical/surgical condition requiring medical management by incontinence supplies as dressings

2. Defined length of treatment anticipated, and

3. Prescription for specific incontinence supplies.

- **NURSING FACILITY SERVICES**

Description. Nursing facility (NF) services for FFS members are covered by AHCCCS for up to 90 days per contract year if the member's medical condition would otherwise require hospitalization. Per 9 A.A.C. 22, Article 2, in lieu of a NF, the member may be placed in an alternative living facility or receive home and community based services. PA is required for these services prior to admission of the member, except in those cases for which retroactive eligibility precludes the ability to obtain PA. However, the case is subject to medical review.

Refer to Chapter 300, Policy 310, and Chapter 1200 for complete information regarding covered long term care services.

Procedures. PA requests may be submitted via mail, fax or telephone. Initial PA will be for a period not to exceed the anticipated enrollment period of the FFS eligible member or what is determined as a medically necessary length of stay, whichever is shorter (not to exceed 90 days) and includes any day covered by Medicare.

Reauthorization for continued stay is subject to concurrent utilization review and continued eligibility.

Prior to nursing home placement of AHCCCS members who choose to receive services through the Indian Health Service (IHS), the NF must obtain a written referral form from IHS. (In circumstances where retroactive eligibility precludes the ability to obtain an IHS referral, this requirement is waived.)

AHCCCS/DFSM/PA Unit staff will request hospital personnel and/or NF staff, whichever is appropriate, to initiate an ALTCS application for possible coverage of nursing facility services if it is believed that the member will need a NF stay lasting longer than 90 days.

- **OBSERVATION SERVICES THAT EXCEED 24 HOURS**

Description. Observation services are those reasonable and necessary services provided on a hospital's premises for evaluation to determine whether the member should be admitted for inpatient care, discharged or transferred to another facility. Observation services include: the use of a bed, periodic monitoring by hospital nursing personnel or, if appropriate, other staff necessary to evaluate, stabilize or treat medical conditions of a significant degree of instability and/or disability on an outpatient basis.

It is not observation status when a member with a known diagnosis enters a hospital for a scheduled procedure/treatment that is expected to keep the member in the hospital for less than 24 hours. This is an outpatient procedure, regardless of the hour in which the member presented to the hospital, whether a bed was utilized or whether services were rendered after midnight.

Extended stays after outpatient surgery must be billed as recovery room extensions.

Observation services must be provided in a designated "observation area" of the hospital unless such an area does not exist.

Refer to Chapter 300, Policy 310, for complete information regarding covered outpatient health services.

Procedures. The AHCCCS/DFSM/PA Unit must be notified when observation services extend beyond the 24 hour limit for fee-for-service members. Clear documentation must be presented in the medical record for the extension of observation status. Documentation in the physician's notes must include, at a minimum, these criteria:

1. Condition necessitating observation admission

2. Justification of need to continue observation, and\or

3. Discharge plan.

Medical Records Documentation

The following are required in medical record documentation:

1. Orders for observation status must be written on the physician's order sheet, not the emergency room record, and must specify, "admit to observation". Rubber stamped orders are not acceptable.

2. Follow-up orders must be written at least every 24 hours.

3. Changes from "observation status to inpatient" or "inpatient to observation status" must be ordered by a physician or authorized individual.

4. Changes from inpatient to observation status must occur within 12 hours after the admission as an inpatient and have supporting medical documentation.

All observation services will be subject to medical review. Medical review for continued observation status will consider each case on an individual basis.

- **PHYSICIANS AND PRIMARY CARE PROVIDERS**

Description. Physicians and other primary care providers (PCPs) must adhere to the PA requirements identified in this policy manual (Chapter 300, Chapter 400 and Chapter 800).

Refer to Chapter 300, Policy 310 for complete information regarding covered PCP and physician services.

Fee-for-service surgeons, or the hospital employing the surgeon, must obtain a separate and distinct AHCCCS PA number from that of the hospital prior to providing the transplantation and elective/non-emergency surgeries (except voluntary sterilization). (See Hospital Inpatient Service Authorization.) The AHCCCS Transplant Coordinator responds to all transplant requests. Assistant surgeons essential to the service and anesthesiologists do not require a PA number.

Procedures. PA requests may be submitted via mail, fax or telephone prior to providing service.

- **PODIATRY SERVICES**

Description. Routine foot care will only be covered for members with a systemic disease requiring the care of a physician. In addition, the disease must be of sufficient severity that performance of such procedure by a nonprofessional person would be hazardous. Routine foot care includes the cutting or removal of corns or calluses; the trimming of nails (including mycotic nails) and other hygienic and preventive maintenance care typically within the realm of self-care.

Refer to Chapter 300, Policy 310, for complete information regarding covered podiatry services.

All podiatry services not covered by Medicare require PA.

Coverage for approved routine foot care must not exceed two visits per quarter or eight visits per contract year. Coverage for mycotic nail treatments will not exceed one bilateral mycotic nail treatment (up to 10 nails) per 60 days. This coverage limitation does not apply to members who are under the age of 21 in both the Medicaid (EPSDT program) and the KidsCare programs.

Procedures. PA requests for podiatry services may be submitted via mail, fax or telephone.

- **PRESCRIPTION DRUG/PHARMACY SERVICES**

Description. FFS pharmacy services that exceed $500.00 per prescription require PA. All FFS pharmacy PA is conducted through the AHCCCS pharmacy Contractor.

All pharmacy claims are subject to post-payment review pursuant to Arizona Revised Statutes §36-2903.01.

Refer to Chapter 300, Policy 310, for complete information regarding covered prescription drug/pharmacy services.

- **REHABILITATION THERAPIES (OCCUPATIONAL, PHYSICAL AND SPEECH)**

Description. Facilities and independent rehabilitative therapists (occupational, physical and speech therapists not employed by the in-patient hospital or nursing facility providing the service) must obtain separate and distinct prior authorization (PA) numbers for rehabilitation therapies.

AHCCCS covers therapy services if the following conditions are met (these conditions do not apply to members who are under the age of 21 in both the Medicaid [EPSDT program] and KidsCare programs):

1. The member's medical condition for which services are prescribed is acute

2. In the case of speech therapy, the member had functional communicative skills prior to the acute event, and

3. There is reasonable expectation of improvement/response to plan of therapy, and there must be documented progress.

AHCCCS covers outpatient speech or occupational therapy only for members who are under the age of 21 in both the Medicaid (EPSDT program) and KidsCare programs, and ALTCS-enrolled members of any age. For other members, refer to Chapter 300, Policy 310.

Refer to Chapter 300, Policy 310 for complete information regarding covered rehabilitation services and Chapter 1200 for complete information regarding rehabilitation services for ALTCS.

Procedures. In addition to information required for all PAs (specified in Policy 810 of this chapter) the following written documentation must be received by the AHCCCS/DFSM/PA Unit prior to the issuance of a PA number:

1. Nature, date, extent of injury/illness and initial therapy evaluation

2. Treatment plan, including specific services/modalities of each therapy, and

3. Expected duration and outcome of each therapy provided.

Upon concurrent review and/or receipt of above documentation, which substantiates AHCCCS rehabilitation requirements, authorization will be given.

Progress notes must be submitted to the AHCCCS/DFSM/PA Unit every 10 days, as evidence of patient progress for continued authorization (when there is no concurrent review).

- **TOTAL PARENTERAL NUTRITION**

Description. Total parenteral nutrition (TPN) is the provision of total caloric needs by intravenous route for individuals with severe pathology of the alimentary tract which does not allow absorption of sufficient nutrients to maintain weight and strength appropriate for the individual's general condition.

Amount, Duration and Scope. AHCCCS covers TPN for members 21 years of age and older when it is the only method to maintain adequate weight and strength and for members who are under the age of 21 in both the Medicaid (EPSDT program) and KidsCare programs when TPN is determined medically necessary. The provision of TPN does not have to meet the criterion of being the sole source of nutrition for EPSDT and KidsCare members.

1. Inpatient TPN services do not require PA as long as hospitalization PA procedures have been followed.

2. Facilities and agencies furnishing outpatient TPN services must obtain PA at least one business day prior to initiation of service. Telephone requests are given provisional PA.

3. TPN provided on an inpatient or outpatient basis is not a covered service if the patient:

   a. Has the ability to absorb enteral feedings, or

   b. Has a condition where TPN cannot be expected to return the patient to a functional level of health.

4. Medical review of TPN services may be referred to an outside review agency for determination of medical necessity and compliance with these policies.

5. AHCCCS follows Medicare guidelines regarding the provision of TPN services.

Refer to Chapter 300, Policy 310 for complete information regarding covered TPN services.

Procedures. Written medical documentation substantiating compliance with criteria must be received by the AHCCCS/DFSM/PA Unit within five business days of initial authorization request. Medical documentation must include:

1. History and physical which describes member's condition and diagnosis

2. Physician's orders

3. Dietary assessment, including member's weight

4. Any pertinent progress notes (nursing/physician), which currently reflect the member's dietary, eating and functional status

5. Physician progress notes indicating expected outcome of treatment, and

6. Nursing facility records documenting percentage of each meal's consumption by member.

AHCCCS/DFSM/PA, upon receipt of documentation, will:

1. Approve, if in compliance with nutritional therapy criteria.

2. Review with the AHCCCS Chief Medical Officer, or designee, for determination of coverage, if not in compliance with standard criteria.

3. Return the referral form to provider with findings of:

   a. Approval, date, and note of any limitations; or

   b. Denial of coverage reason.

- **TRANSPLANTATION (ORGAN AND TISSUE)**

Description. Providers must obtain PA from the AHCCCS Transplant Coordinator for all organ and tissue transplantation services to be provided to FFS members. Pursuant to §1903(v) of the Social Security Act and 9 A.A.C. 22, Article 2, FESP members are not eligible for transplantation services.

Refer to Chapter 300 (Policy 310 and Attachments A and B) in this manual for complete information regarding covered transplantation services.

AHCCCS also requires providers to obtain PA for transplant related services provided to AHCCCS members who have undergone transplantations not covered by AHCCCS.

AHCCCS utilization management requirements, including PA, are identified below.

Procedures. FFS provider responsibilities regarding medically necessary organ and tissue transplantation services for eligible members include, but are not limited to:

1. The member's transplantation specialist (hematologist/oncologist, cardiologist, gastroenterologist, nephrologist, etc.) must submit a written request to the AHCCCS Transplant Coordinator for approval of the transplantation.

2. The following documentation must accompany the written request:

    a. Current history and physical, including information regarding previous therapy for the disease requiring covered organ and tissue transplantations

    b. Records of diagnostic studies documenting the diagnosis, member's current medical status and plan of treatment leading to the recommendation of transplantation

    c. Summary of anticipated outcome for the member.

3. The AHCCCS Transplant Coordinator will verify the member's eligibility. If approval is requested at the end of a month, eligibility will be verified for the following month.

4. The AHCCCS Chief Medical Officer, or designee, will review the submitted documentation, consult with appropriate specialists when necessary, and inform the member's transplantation specialist whether or not transplantation is approved. Written approval will include the following information:

    a. Designation of the appropriate transplant centers with which AHCCCS maintains a contract, and

    b. Instructions for obtaining PA for each transplantation service component.

5. AHCCCS will monitor convalescence via progress reports submitted to the Transplant Coordinator.

6. Providers must submit claims in accordance with AHCCCS policies and procedures.

Refer to the AHCCCS FFS Provider Manual for additional information. This manual is available on the AHCCCS Web site.

In addition to the PA requirements, providers:

1. Submit to the AHCCCS Transplant Coordinator utilization abstracts that include new treatments, medical progress and/or complications, and laboratory results. Weekly submissions begin with the member's approval for transplantation and end with discharge from convalescent care.

2. Offer recommendations for the ongoing treatment and monitoring of the member after discharge.

3. Cooperate with requests from the AHCCCS Transplant Coordinator to supply summary data for outcomes studies.

PA requests for transplant-related services provided to AHCCCS members who have undergone transplantations not covered by AHCCCS may be submitted via mail, fax or telephone.

- **TRANSPORTATION**

Description. AHCCCS covers the following transportation services:

1. Emergency

2. Medically necessary (non-emergency), and

3. Medically necessary maternal and newborn transportation.

Emergency transportation - Emergency transportation does not require PA from the AHCCCS/DFSM/PA Unit, although such services are only covered to the nearest medical facility which is medically equipped and staffed to provide appropriate medical care.

Emergency transport to out-of-state facilities is covered only when the out-of-state facility is the nearest appropriate facility.

Medically necessary non-emergency transportation – PA is required for medically necessary (non-emergency) transportation when the mileage is greater than 100 miles round trip. Medically necessary transportation of 100 miles or less, round trip, does not require PA.

Transportation is limited to the cost of transporting the member to a registered provider capable of meeting the member's medical needs. Transportation must only be provided to transport the member to and from the required covered medical service.

Maternal and newborn transportation - Medically necessary maternal and newborn transportation, as specified in Chapter 300, does not require PA.

Refer to Chapter 300, Policy 310 for a complete description and discussion of covered transportation services.

Procedures. In addition to requirements for all PAs (specified in Policy 810 of this chapter) the following conditions must also be met when PA is requested for non-emergency medically necessary transportation.

The following information must be provided when requesting PA either by telephone or via fax:

1. Physician's order

2. Descriptions of disability requiring special transport and/or special circumstances

3. Type of transportation and need for attendant services, as appropriate

4. Estimated cost of transportation, attendant services, meals or lodging, as appropriate

5. Verbal or written representation from the member that other transportation is not available.

PA for non-emergency medically necessary transportation provided to AHCCCS FFS members or IHS-enrolled members through the use of a private vehicle must be requested by the member's medical service provider. PA for transportation will not be issued unless the transportation provider is an AHCCCS registered provider prior to seeking PA.

Refer to the AHCCCS FFS Provider Manual or AHCCCS IHS Billing Manual for provider registration and billing information. Both of these manuals are available on the AHCCCS Web site.

- **TRIAGE/SCREENING AND EVALUATION OF EMERGENCY MEDICAL CONDITIONS**

Description. Triage/emergency medical screening and evaluation services are the medically necessary screening and assessment services provided to FFS, acute care and ALTCS members in order to determine whether or not an emergency medical condition exists, the severity of the condition, and those services necessary to alleviate or stabilize the emergent condition. These services are covered services if they are delivered in:

1. An acute care hospital emergency room

2. A free standing urgent care center, or

3. An Indian Health Service (IHS) hospital emergency room. This applies only to emergency medical assessment services provided to Native Americans who are enrolled with a Contractor but receive the triage/emergency medical assessment services through an IHS hospital.

Amount, Duration, and Scope. Medically necessary screening and evaluation services to rule out an emergency condition, or to determine the severity of an emergency medical condition and necessary treatment services required for the emergency medical condition, do not require prior authorization (PA) from the AHCCCS/DFSM/PA Unit.

If the presenting condition assessed during triage/emergency medical screening and evaluation is determined not to be an emergency condition, any further assessment, care and treatment is subject to AHCCCS FFS PA and utilization management requirements.

Providers responsible for triage, screening and/or evaluation of emergency medical conditions must submit supporting medical documentation for services rendered. At a minimum, the emergency room record of care must be submitted when reporting or billing services to the AHCCCS Administration for services provided to FFS members.

Medical review of emergency room records must consider each case on an individual basis to determine if:

1. The triage/screening services were reasonable, cost-effective and medically necessary to rule out an emergency condition and evaluate the member's medical status, and

2. The evaluation of the member's medical status meets criteria for severity of illness and intensity of service.

If the provider fails to submit medical records necessary for review, or if the medical records fail to meet the criteria specified in this policy, the claim may be denied.

Refer to Policy 810 of this Chapter for a description of notification and PA procedures for inpatient admission or post-assessment therapy.

Refer to the AHCCCS FFS Provider Manual for information regarding service reporting and billing requirements. This manual is available on the AHCCCS Web site.

EXHIBIT 820-1

AHCCCS
HYSTERECTOMY CONSENT FORM

EXHIBIT 820-1

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
(AHCCCS)
HYSTERECTOMY CONSENT FORM

A hysterectomy is the removal of the whole uterus (womb). A hysterectomy cannot be revised and it will permanently prevent you from having children. A hysterectomy should only be performed when there is a disease of the woman's uterus or some other problem that can only be treated by removing the uterus. It is a serious operation and there are discomforts and a chance of serious health problems.

AHCCCS does not cover hysterectomy procedures when performed only for the purpose of rendering an individual sterile.

By signing below, I hereby consent of my own free will to undergo a hysterectomy, which will render me permanently incapable of reproducing. My signature also acknowledges that I have read and understood the above information.

Patient Signature	Date

Patient AHCCCS Identification Number	Patient Social Security Number

In accordance with Federal Regulation 42 C.F.R. §441.255, the signature and date below are required in order for reimbursement to be made.

Person who obtained the patient's consent to the hysterectomy	Date

Revision Date: March, 1998

830 QUALITY AND UTILIZATION MANAGEMENT FOR HOSPITAL SERVICES

Through an Intergovernmental Agreement between AHCCCS and the Arizona Department of Health Services (ADHS), Division of Assurance and Licensure, AHCCCS monitors the quality of medical facility services. ADHS provides inspection reports to AHCCCS in order to verify compliance with applicable Federal and State requirements, e.g., Title 42 of the Code of Federal Regulations (42 CFR), Part 456, Subpart C for acute hospitals.

Refer to Chapter 900 and Chapter 1000 for a complete description and discussion of quality and utilization management for AHCCCS Contractors.

• UTILIZATION REVIEW – RURAL HOSPITALS

Description. Utilization review (UR) for AHCCCS FFS patients hospitalized in rural hospitals must be performed by the hospital's Utilization Management (UM)/UR department. This policy applies to rural hospitals in which on-site reviews are not performed.

Procedures.

1. Rural hospital personnel must report to the AHCCCS PA nurse any FFS AHCCCS members (any eligible member that is not enrolled in a Contractor) admitted for hospitalization.

2. The AHCCCS PA nurse will initiate the UM process by granting a provisional authorization or denying admission. Authorized admission will be assigned initial length-of-stay.

3. The hospital UM nurse must review the member's stay in accordance with 42 CFR Section 456, Subpart C.

4. Extensions of stay, certified as medically necessary by the hospital UM nurse, must be promptly reported to the AHCCCS PA nurse for approval.

5. Upon member's discharge, copies of the UM worksheet(s) must be submitted to the AHCCCS/DFSM/PA Unit.

6. Upon receipt and review of the UM worksheet, final authorization for services will be granted or denied.

840 INDIAN HEALTH SERVICE REFERRAL POLICY

Description. AHCCCS Indian Health Service (IHS) members may choose to receive services through IHS or a 638 Tribal Facility. Services not available through IHS or a 638 Tribal Facility can be provided by AHCCCS FFS providers, upon referral by an IHS or a 638 Tribal Facility provider, and billed to the AHCCCS Administration. Services provided in an IHS or 638 Tribal Facility are the responsibility of IHS or the 638 Tribal Facility. All referrals made must be for medically necessary services, which are initiated and approved by IHS or the 638 Tribal Facility. In circumstances where retroactive eligibility precludes the ability to obtain an IHS or 638 Tribal Facility referral, this requirement is waived. Referrals can only be made for services not available through IHS or a 638 Tribal Facility.

Reimbursement of non-IHS providers (for services rendered to IHS or 638 Tribal Facility enrolled AHCCCS members) is contingent upon the presence of an IHS or a 638 Tribal Facility referral when a claim is submitted to AHCCCS for the following covered services:

1. Elective inpatient hospital admissions
2. Elective surgeries
3. Non-emergency medically necessary transportation (as specified in Chapter 300, Policy 310 addressing Transportation for Native American AHCCCS Members Enrolled with IHS or a 638 Tribal Facility)
4. Durable medical equipment/medical supplies
5. Non-emergent dental services
6. Eyeglasses, and
7. Admissions to nursing facilities, in lieu of inpatient hospitalization (up to 90 days per contract year). The 90 days of AHCCCS acute care coverage for NF services begins on the day of admission regardless of whether the member is insured by a third party insurance carrier, including Medicare.

Claims submitted without an attached IHS or 638 Tribal Facility referral are subject to denial. Claims are also subject to medical review to substantiate medical necessity and provision of services in accordance with AHCCCS rules and policies.

Procedures. The IHS or 638 Tribal Facility provider must supply the AHCCCS Non-IHS provider with a completed referral form prior to or at the time services are rendered.

The completed referral from IHS or the 638 Tribal Facility must contain the following information:

1. Member's name and AHCCCS ID number

2. Name, title, and address of referring provider

3. Date referred

4. Name and address of provider to whom member is being referred, and

5. Explanation for the referral, including diagnosis and reason for the referral.

A non-IHS provider rendering AHCCCS covered services, upon referral from IHS or a 638 Tribal Facility, must obtain PA from the AHCCCS/DFSM/PA Unit for services specified in Policy 820 of this Chapter when scheduling an appointment or admission for the referred member.

If non-emergency medically necessary transportation is required, the referring IHS or 638 Tribal Facility service provider must submit an IHS or 638 Tribal Facility referral to the AHCCCS/DFSM/PA Unit for approval prior to service delivery (this applies to all non-emergency medically necessary transportation). PA for transportation services will not be issued to a transportation provider until or unless an IHS or a 638 Tribal Facility referral has been received by the AHCCCS/DFSM/PA Unit.